

Report on social determinants of health and the health divide in the WHO European Region

Executive summary

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The senior advisers were Guillem Lopez Casanovas, Zsuzsa Ferge, Ilona Kickbusch, Johan Mackenbach, Tilek Meimanaliev, Amartya Sen, Vladimir Starodubov, Tomris Turmen, Denny Vagero, Margaret Whitehead and ex-officio representatives of WHO and the European Commission.

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Executive summary

This study of inequities in health between and within countries across the 53 Member States of the European Region was commissioned to support the development of the new health policy framework for Europe: Health 2020. Much more is understood now about the extent, and social causes, of these inequities, particularly since the publication in 2008 of the report of the Commission on Social Determinants of Health (1). This European study builds on the global evidence.

There are good reasons for the specific European focus of this review. Health inequities across the Region are known to be high, and the Region's great diversity creates opportunities to offer policy analysis and recommendations specific to low-, middle- and high-income countries. The results of the review are clear: with the right choice of policies, progress can be made across all countries, including those with low incomes.

The Review comes at an important moment in European history. The WHO European Region includes countries with close to the best health and narrowest health inequities in the world. The evidence suggests that this welcome picture is related to a long and sustained period of improvement in the lives people are able to lead – socially cohesive societies, increasingly affluent, with developed welfare states and high-quality education and health services. All these have created the conditions for people to have the freedom to lead lives they have reason to value. Remarkable health gains have been the result.

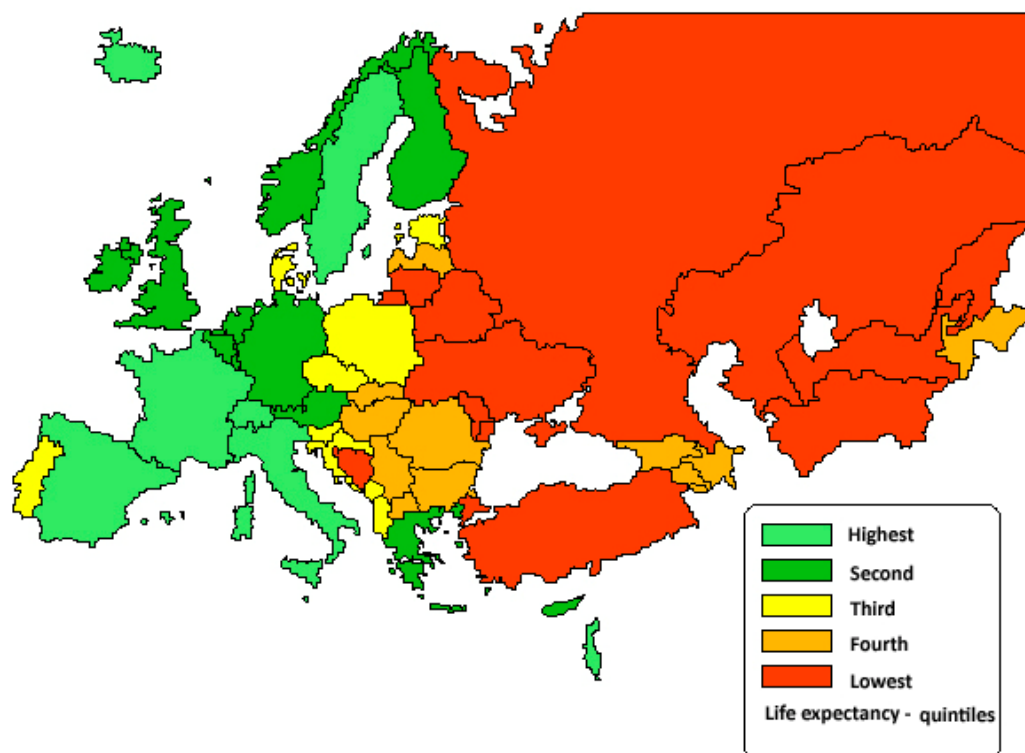
However, not all countries have shared fully in this social, economic and health development. Although social and economic circumstances have improved in all countries, differences remain and health has suffered. Further, even more affluent countries in the Region have increasingly seen inequities in people's life conditions and declining social mobility and social cohesion. As a likely result of these changes, health inequities are not diminishing and are increasing in many countries. The economic crisis since 2008, more profound and extended than most people predicted, has exacerbated this trend and exposed stark social and economic inequities within and between countries.

Human rights approaches support giving priority to improving health and reducing inequities. Achieving these goals requires definitive action on the social determinants of health as a major policy challenge. These inequities in health are widespread, persistent, unnecessary and unjust, and tackling them should be a high priority at all levels of governance in the Region. Necessary action is needed across the life course and in wider social and economic spheres, to protect present and future generations.

This Review provides guidance on what is possible and what works, to be considered within the specific circumstances and settings of individual countries. Its recommendations are practical and focused. One response open to all is to ensure universal coverage of health care. Another is to focus on behaviour – smoking, diet, and alcohol – that cause much of these health inequities but are also socially determined. The review endorses both these responses. But the review recommendations extend further – to the causes of the causes: the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to them.

Fig. 1 shows life expectancy in countries, which is one measure of differences in health across the Region. Most countries in the lowest quintile are in the eastern part of the Region. The range between the highest and lowest figures for countries in the Region is 17 years for men and 12 years for women.

Fig. 1. Life expectancy in countries in the WHO European Region, 2010 (or latest available)

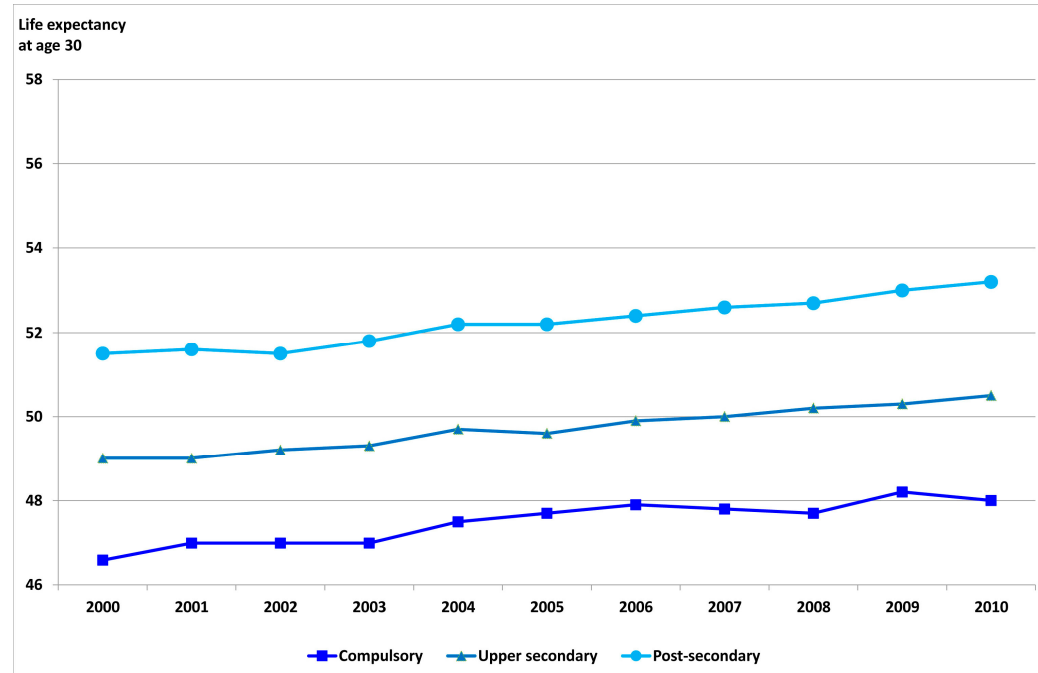


Source: European Health for All database [online database] (2).

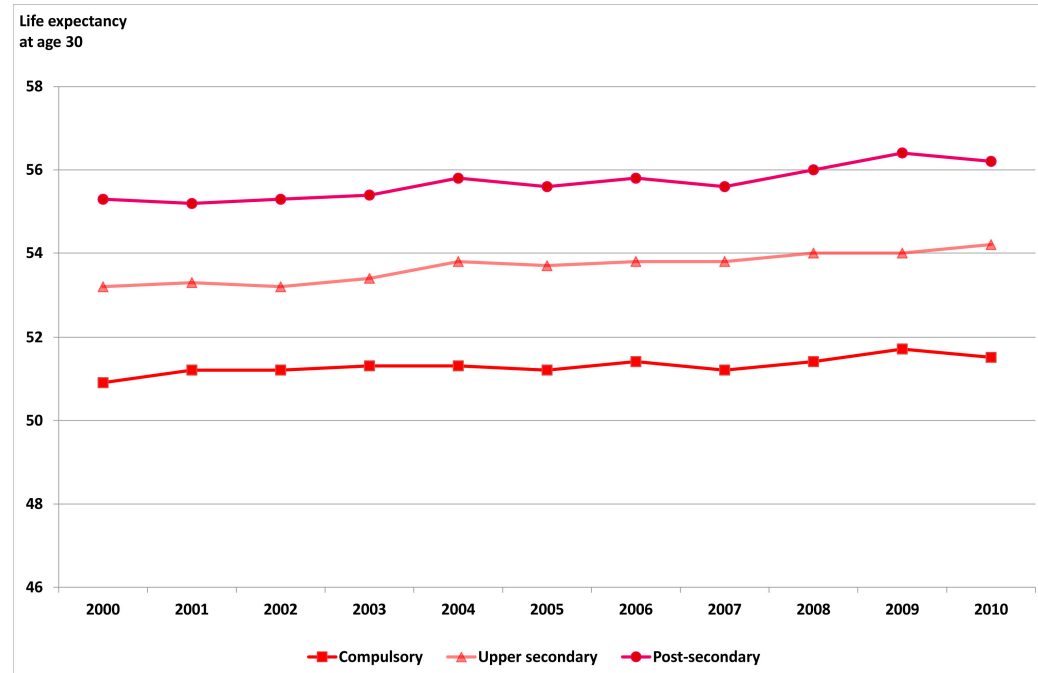
Further, health inequities are not confined to poor health for people in poor countries and good health for everyone else. Fig. 2 shows how health inequities persist even in some of the most affluent countries.

Fig. 2. Life expectancy in Sweden by educational level and sex, 2000–2010

Men



Women



Source: *Livslängden i Sverige 2001–2010 [Life expectancy in Sweden, 2001–2010] (3).*

To address these health inequities within and between countries, the WHO Regional Office for Europe commissioned this review of social determinants of health and the health divide. The conclusions and recommendations of this review have informed development of Health 2020, the new health strategy for the WHO European Region.

Health inequalities that are avoidable are unjust: action is required across society

Systematic differences in health between social groups that are avoidable by reasonable means are unfair. This review therefore uses the term health inequities to describe these avoidable inequalities.

The analysis shows that action is required across the whole of government, on the social determinants of health, to achieve advances in health equity. Health ministers clearly have a role in ensuring universal access to high-quality health services. However, they also have a leadership role in advancing the case that health is an outcome of policies pursued in other arenas. So close is the link between social policies and health equity that the magnitude of health inequity shows how well society is meeting the needs of its citizens. Health is not simply a marker of good practice but is also highly valued by individuals and society.

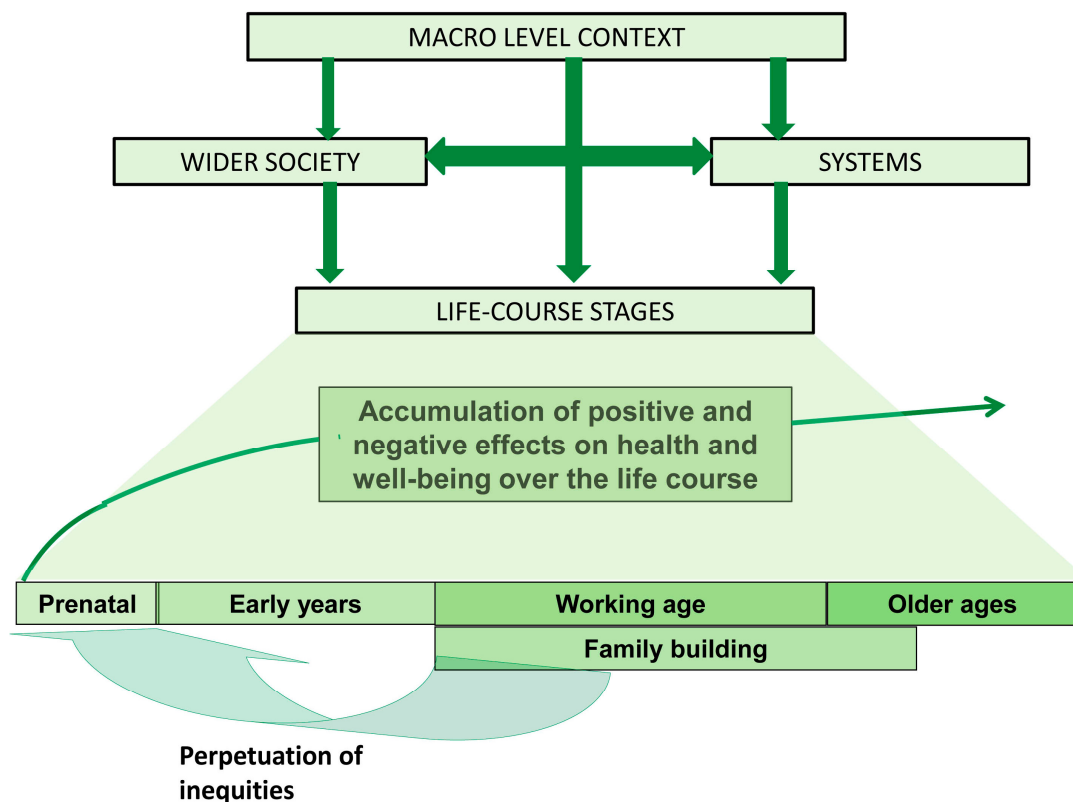
The review makes the moral case for action on social determinants of health – social injustice kills and causes unnecessary suffering. There is also a strong economic argument. The cost of health inequities to health services, lost productivity and lost government revenue is such that no society can afford inaction. Tackling inequities in the social determinants of health also brings other improvements in societal well-being, such as greater social cohesion, greater efforts for climate change mitigation and better education.

Areas for action – emphasizing priorities

Reviewing the experience of countries in the European Region clearly shows that countries should have two clear aims: improving average health and reducing health inequities by striving to bring the health of less advantaged people up to the level of the most advantaged. Improving the levels and equitable distribution of the social determinants should achieve both aims. Similarly, reducing health gaps between countries requires striving to bring the level of the least healthy countries up to that of the best. To achieve this, two types of strategy are needed: within each country, action on the social determinants of health to improve average health and reduce health inequities; and action at the transnational level to address the causes of inequities between countries.

The review commissioned 13 task groups that reviewed European and world literature on social determinants of health and strategies to promote health equity within and between countries. Based on the evidence assembled, the review grouped its recommendations into four themes – life-course stages, the wider society, the macro-level broader context and systems – shown in Fig. 3. Action is needed on all four themes.

Fig. 3. Broad themes



Within each of these themes, the highest priorities for action are as follows:

A. The life course

- B. The highest priority is for countries to ensure a good start to life for every child. This requires, as a minimum, adequate social and health protection for women, mothers-to-be and young families and making significant progress towards a universal, high-quality, affordable early-years, education and child care system.

Emphasis on a good start in life does not of course mean that actions at later stages of the life course are not important – working ages and older ages. They are crucial both to reinforce the improvement in skills and individual empowerment provided by a good start but also to achieve greater health equity among the existing adult populations of each country. In particular, it is essential to reduce stress at work, reduce long-term unemployment through active labour market programmes and address the causes of social isolation.

C. Wider society

The most effective actions to achieve greater health equity at a societal level are actions that create or reassert societal cohesion and mutual responsibility. In particular, the most tangible and practical action is to ensure an adequate level and distribution of social protection, according to need. In many countries, this requires improving the level of provision. In all countries, it necessitates making better use of existing provision – such as making progress to increase the proportion of people who have the minimum standard of living needed to participate in society and maintaining health.

Supporting action to create cohesion and resilience at the local level is essential through a whole-of-society approach that encourages the development, at the local level, of partnerships with those affected by inequity and exclusionary processes – working with civil society and a range of civic partners. Central to this approach is empowerment – putting in place effective mechanisms that give those affected a real say in decisions that affect their lives and by recognizing their fundamental human rights – including the right to health.

D. Macro-level context

Wider influences, both within countries and transnationally, shape the lives, human rights and health of people in the European Region. In the short to medium term, the priority is to address the health effects of the current economic crisis. Recognition of the health and social consequences of economic austerity packages must be a priority in further shaping economic and fiscal policy in European countries. The views of ministers responsible for health and social affairs must be heard in the negotiations about such austerity packages. In particular, at the transnational level, WHO, UNICEF and the International Labour Organization (ILO) should also be given a voice.

Equity between generations – intergenerational equity – is a fundamental driver of environmental policy. So must it be for societal policies for health. It is critical that approaches to environmental, social and economic policy and practice be integrated.

E. Systems

Improvements in health and its social determinants will not be achieved without significantly refocusing delivery systems to whole-of-government and whole-of-society approaches. The starting-point is the health system – what it does itself and how it influences others to achieve better health and greater equity. This requires achieving greater coherence of action across all sectors (policies, investments and services) and stakeholders (public, private and voluntary) at all levels of government (transnational, national, regional and local). Universal access to health care is a priority – where this is established, it is to be protected and must progressively be extended to all countries in the Region.

Action on disease prevention must include reducing the immediate causes of inequity within and between countries – alcohol consumption, smoking and obesity. Effective strategies go beyond providing information and include taxation and regulation. Evidence suggests that addressing the causes of the causes is the right way to proceed on these – ensuring that people have the skills and control over their lives to be able to change behaviour.

But nothing will happen without monitoring and adequate review. It is recommended that all 53 countries in the Region establish clear strategies to redress the current patterns and magnitude of health inequities by taking action on the social determinants of health. Countries should undertake regular reviews of these strategies. These should be reported to WHO and discussed at regular regional meetings.

New approaches

This European review draws on the findings and recommendations of the Commission on Social Determinants of Health (1): health inequities arise from the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to these

conditions of daily life. The explicit purpose of the review was to assemble new evidence and to develop new ideas that could be applied to the remarkable diversity of countries that make up the European Region; different in national income, social development, history, politics, and culture.

Box 1 summarizes distinct approaches of the review to understanding and promoting health equity across Europe.

Box 1. Key issues in understanding and promoting health equity

- There is a **social gradient in health**. Health becomes progressively better as the socioeconomic position of people and communities becomes higher. It is important to design policies that act across the whole gradient and to address the people at the bottom of the social gradient and the people who are most vulnerable.
- To achieve both these objectives, we propose policies that are universal but with attention and intensity that is proportionate to need – proportionate universalism.
- **Social determinants of health** – we must address the conditions in which people are born, grow, live, work and age – key determinants of health equity. These conditions of daily life are, in turn, influenced by structural drivers: economic arrangements, distribution of power, gender equity, policy frameworks and the values of society.
- Taking a **life-course approach** to health equity. There is an accumulation of advantage and disadvantage across the life course. This approach begins with the important early stages of life – pregnancy and early child development – and continues with school, the transition to working life, employment and working conditions and circumstances affecting older people.
- In relation to the most excluded people, it is important to address the **processes of exclusion** rather than focusing simply on addressing particular characteristics of excluded groups. This approach has much potential when addressing the social and health problems of Roma and irregular migrants as well as those who suffer from less extreme forms of exclusion and dip in and out of vulnerable contexts.
- The **resilience, capabilities and strength of individuals and communities** need to be built on and the hazards and risks to which they are subjected need to be addressed.
- Much focus has been, and will continue to be, on **equity within generations**. The perspectives of sustainable development and the importance of social inequity affecting future generations means that **intergenerational equity** must be emphasized, and the impact of action and policies for inequities on future generations must be assessed and risks mitigated.
- **Gender equity** is important – all the **social determinants of health** may affect the sexes differently. In addition to biological sex differences, there are fundamental social differences in how women and men are treated and the assets and resilience they have. In all societies, to varying degrees these gender relations affect health and should shape actions taken to reduce inequities.

Several new themes emerged from the review.

- Human rights are central to our approach to action on the social determinants of health; human rights embody fundamental freedoms and the societal action necessary to secure those.
- In addition to addressing harmful influences, it is important to build on the resilience of individuals and communities; empowerment is central.
- The life course emerges as the right way to plan action on social determinants of health; although the review emphasizes early childhood, action is needed at every stage of life, and it makes strong recommendations for working and older ages.
- Protecting future generations from the perpetuation of social and economic inequities affecting previous generations is important.
- Intergenerational equity features strongly in addition to intragenerational equity.
- Strong emphasis is needed on joint action on social determinants of health, social cohesion and sustainable development; all imply a strong commitment to social justice.
- Proportionate universalism should be used as a priority-setting strategy in taking action to address health inequity.

The European Region does not need to be so divided in health, depressed by gloomy economic prospects and failing in its environmental ambitions. Instead, the review suggests, it could move towards health equity, sustainable prosperity and social cohesion across the whole Region. This requires that the 53 WHO Member States in the European Region work together and take mutual responsibility to achieve this change.

Do something, do more, do better

This was a key message emerging from the work of the task groups set up to review what would work in the variety of countries of the European Region: do something, do more, do better.

In other words, if countries have very little in place in terms of policies on social determinants of health, some action matters. Where there are some existing policies, this review shows how these can be improved to deal with large and persistent health inequities. In the richest countries in Europe, there is scope to do better on these inequities.

The review, drawing on the research evidence brought together by the task groups, gives recommendations that apply across the diversity of countries in the Region but gives many specific examples of how these can be applied in different country contexts. Empowerment, a basic tenet of the review, means not imposing solutions from outside but countries, regions and cities using the scientifically based recommendations in this report to develop policies and programmes specific to each of the 53 Member States and, indeed, to cities and districts within those countries.

Social determinants, human rights and freedoms

There is vibrant debate on what is sometimes portrayed as a tension between action on social determinants and individual freedoms. This review calls for social action – but individual freedoms and responsibilities feature strongly in the approach taken, drawing on Amartya Sen's

insights on freedoms to enable people to lead a life they have reason to value (4). The wider influences of society on the social determinants of individual health are of fundamental importance in enabling people to achieve the capabilities that lead to good health.

An individual's resources and capabilities for health are influenced by social and economic arrangements; by collective resources provided by the communities of which they are part; and by welfare state institutions. Human rights approaches can support these resources. The right to health entails rights to equity in the social determinants of health. In other words, as Sridhar Venkatapuram (5) has argued, the right to health should be understood as a moral claim on the "capability to be healthy", which is determined largely by the social determinants of health.

Action in a cold economic climate

The review argues the moral case for action. In many areas the moral and the economic case for action come together – investment in early child development and education may meet the demands both of efficiency and justice. As a companion study for Health 2020 notes, prevention is a "good buy" (6). Further, action on social determinants of health leads to other benefits to society, which may in turn have more immediate economic benefits. For example, a more socially cohesive, educated population is likely to have lower rates of crime and civil disorder, a more highly skilled workforce and enable people to lead lives they have reason to value, as well as having better health and greater health equity.

Current economic difficulties in countries are a reason for action and not inaction on social determinants of health. The economic crisis affecting Europe provides the stark background and the urgent challenge to this work. It is often argued that coping with these severe economic difficulties requires reducing investment in health and its social determinants. Yet the evidence laid out in this review is clear: investing in early child development, active labour market policies, social protection, housing and mitigating climate change will help protect populations from the adverse effects of the economic crisis and lay the basis for a healthier future.

Recommendations and action required

Theme A – Life course

Perpetuation of inequities across generations

Recommendation 1(a)

Provide adequate social and health protection for women, mothers-to-be and young families

Specific actions

- (i) Ensure that all women and girls have accessible, affordable and high-quality sexual and reproductive health services. This includes access to modern contraception and care in pregnancy and childbirth. Aside from safe delivery as a basic right, such services help to decrease smoking rates in pregnancy and increase breastfeeding and provide support for effective parenting. These services should identify families at risk early and refer to appropriate services.
- (ii) Ensure that strategies to reduce social and economic inequities benefit women of childbearing age and families with young children.
- (iii) Health ministers should act as advocates for social systems that provide income protection, adequate benefits and progressive taxation to reduce poverty among children and pensioners.
- (iv) Ensure that parenting policies and services empower women with children to take control over their lives, support the health and development of their children and support a greater parenting role for men. In particular, family-friendly employment policies should be strengthened by introducing more flexible working hours – without turning to insecure short-term contracts – and making affordable childcare available, to help parents combine work with their parental responsibilities.

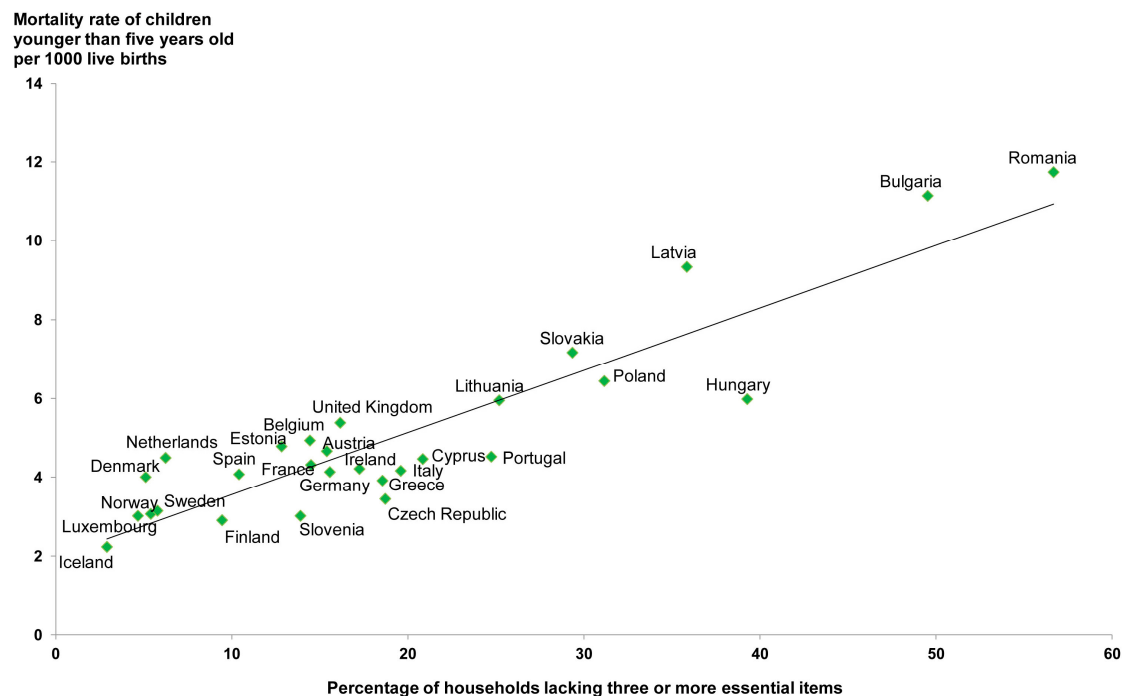
Perpetuation of health risks from one generation to the next

Children's early development, life chances and, ultimately, health inequities are strongly influenced by the social and economic background of their parents and grandparents; location, culture and tradition; education and employment; income and wealth; lifestyle and behaviour; and genetic disposition. Further, conditions such as obesity and hypertension, and behaviour that puts health at risk, such as smoking, recurs in successive generations. Achieving a sustainable reduction in health inequities requires action to prevent the relative and absolute disadvantage of parents from blighting the lives of their children, their grandchildren and subsequent generations. The strongest instruments to break such vicious circles of disadvantage lie at the start of life. The review recommendations address key factors that contribute to perpetuating health inequities.

The interaction between gender inequities and other social determinants increases women's vulnerability and exposure to the risk of negative sexual and reproductive health outcomes. Poor maternal health, inadequate access to contraception and gender-based violence are indicators of these inequities.

As an illustration of the early effect of the perpetuation of inequity on health, Fig. 4 shows that the higher the average level of household deprivation in a country, the greater the chance of a child dying before the age of five years. Deprivation in early life is also associated with other health problems, poor diet and deficits in physical, social, emotional, cognitive and language domains of development. These have lifelong effects on life chances and subsequent health.

Fig. 4. Mortality among children younger than five years of age and percentage of deprived households (lacking three or more essential items) in selected countries in the WHO European Region



Sources: Jonathan Bradshaw and Emese Mayhew, University of York, personal communication, 2010; data from *The state of the world's children 2007* (7) and Eurostat databases [online databases] (8).

Early years

Recommendation 1(b)

Provide a universal high-quality, affordable early-years education and childcare system

Specific actions

- (i) Ensure universal access to a high-quality, affordable early-years education and childcare system as the essential bedrock in levelling social inequities in educational attainment, reducing poverty and promoting gender equality.
- (ii) Make special efforts to include children with disabilities and children from minority ethnic groups, such as Roma, in education services.

Action to promote the physical, cognitive, social and emotional development of children is crucial for all children, starting from the earliest years and reinforced throughout childhood and adolescence. Children who experience a positive start are likely to do well at school, attain better-paid employment and enjoy better physical and mental health in adulthood.

A good start is characterized by the following: a mother is in a position to make reproductive choices, is healthy during pregnancy, gives birth to a baby of healthy weight, the baby experiences warm and responsive relationships in infancy, the baby has access to high-quality childcare and early education, and lives in a stimulating environment that allow safe access to

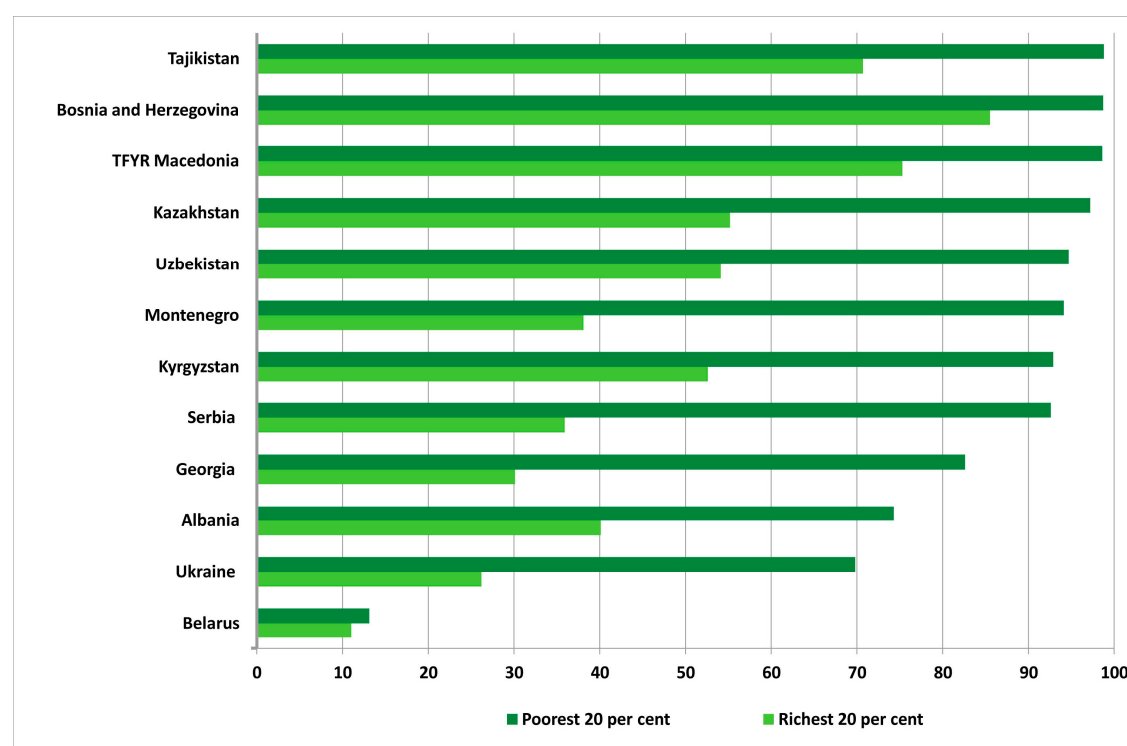
outdoor play. Evidence shows that high-quality early-child services, with effects on parenting, can compensate for the effects of social disadvantage on early child development. Given the nature of early childhood, the services that support this stage of life are intergenerational and multiprofessional: including health, education and social welfare, and aimed at parents as well as children themselves. In most countries, this support is unlikely to be initiated through contact with the formal education sector but through health and childcare services.

The systems that encourage such a good start in life include policies characterized by excellent health care before and after birth, an employment and social protection system that recognizes the risks posed by poverty and stress in early childhood, good parental leave arrangements, support for parenting and high-quality early education and care.

Reinforcing a good start throughout childhood and adolescence requires focusing on parenting skills, the employment and social protection of parents, balancing work and the family life of women and men, equitable education and social support for boys and girls throughout childhood and good systems for developing life and work skills for young people, both during adolescence and early adulthood.

Fig. 5 illustrates the variation in attendance of early education programmes across countries and between the richest and poorest people within each country – children of the poorest parents are less likely to attend than the richest.

Fig. 5. Children aged 36–59 months in the quintiles of the population with the lowest and highest income who do not attend any form of early education programme in selected countries in the eastern part of the WHO European Region



TFYR Macedonia: the former Yugoslav Republic of Macedonia.

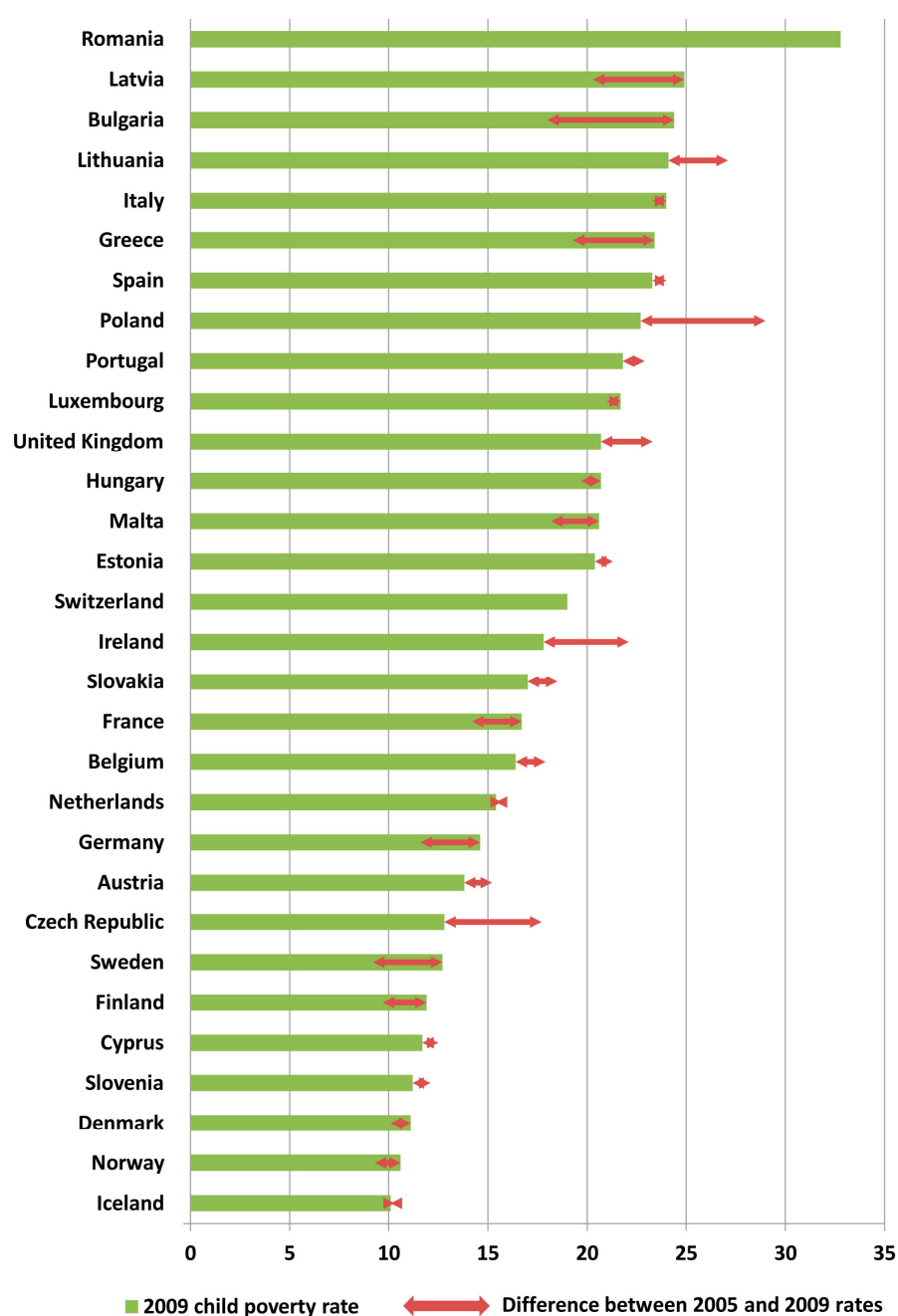
Source: Emerging challenges for children in eastern Europe and central Asia: multiple indicator cluster survey in 12 countries [online database] (9).

Child poverty

Relative poverty in childhood strongly influences health and other outcomes throughout life and remains high in much of the WHO European Region. In the countries in the eastern part of the European Region, despite 10–15 years of economic growth before the current recession, child poverty has been more or less at the same level (10). The main reason why children have not benefited from this economic growth is that the average expenditure on family benefits in this part of the Region was less than 1% of gross domestic product (GDP) versus 2.25% on average in the countries of the Organisation for Economic Co-operation and Development (OECD) in 2007 (11).

In the western part of the Region, despite higher average expenditure compared with the eastern part of the Region, the EU survey of incomes and living conditions in 2009 revealed a huge range of child poverty rates across the EU – from 10% to 33%, shown in Fig. 6 (12). Within countries, the rate changed between 2005 and 2009 by a percentage point or more in 20 of the countries shown, with 11 countries increasing.

Fig. 6. Child poverty rates in selected countries in the WHO European Region in 2009 and change since 2005



Source: personal communication, Jonathan Bradshaw, University of York, based on Eurostat databases [online databases] (8).

Note: The solid bars represent the 2009 child poverty rate, defined as the percentage of children living in families with less than 60% of median income. Where arrows are to the right of the bars, this indicates that poverty rates fell between 2005 and 2009. Where arrows are to the left of the end of the bar, poverty rates increased between 2005 and 2009.

Working age and employment

Recommendation 1(c)

Eradicate exposure to unhealthy, unsafe work and strengthen measures to secure healthy workplaces and access to employment and good quality work.

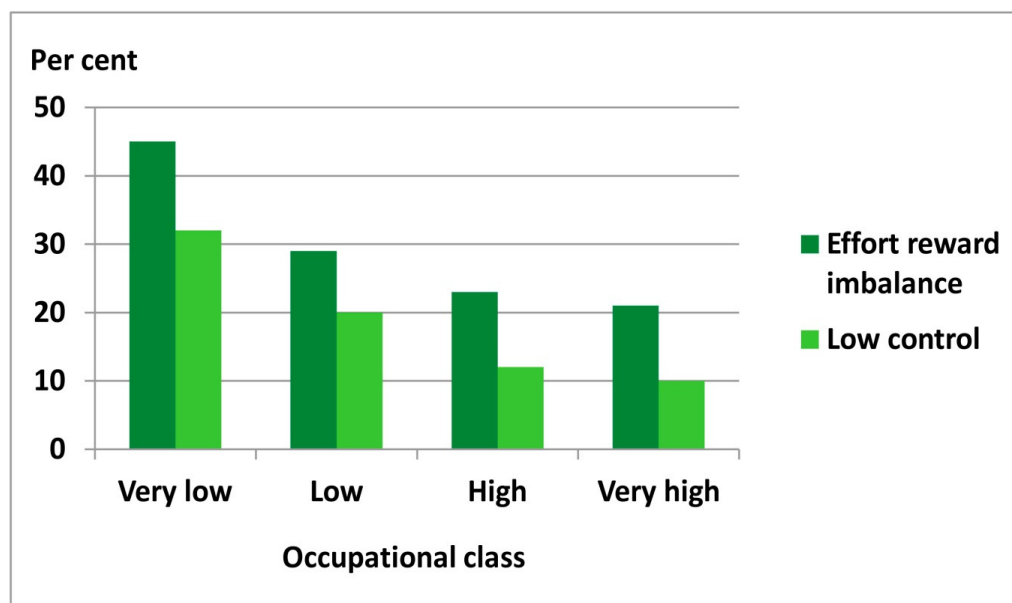
Specific actions

- (i) Improve psychosocial conditions in workplaces characterized by unhealthy stress.
- (ii) Reduce the burden of occupational injuries, diseases and other health risks by enforcing national legislation and regulations to remove health hazards at work.
- (iii) Maintain or develop occupational health services that are financed publicly and are independent of employers.
- (iv) At the international level, intensify and extend the transfer of knowledge and skills in the area of work-related health and safety from European and other international organizations, institutions and networks to national organizations.
- (v) In low- and middle-income countries, give priority to measures of economic growth, in accordance with an environmental and sustainability strategy, that are considered most effective in reducing poverty, lack of education and high levels of unemployment. To achieve this, invest in training, improved infrastructure and technology and extend access to employment and high-quality work throughout major sectors of the workforce.
- (vi) In high-income countries, ensure a high level of employment, in accordance with principles of a sustainable economy, without compromising standards of decent work and policies of basic social protection.
- (vii) Protect the employment rights of and strengthen preventive efforts among the most vulnerable people: especially those with insecure contracts, poorly paid part-time workers, unemployed people and migrant workers.
- (viii) Address rising levels of unemployment among young people by creating employment opportunities and ensuring they take up high-quality work through education, training and active labour market policies.

Employment and high-quality work are critically important for population health and health inequalities in several interrelated ways.

- Participation in or exclusion from the labour market determines a wide range of life chances, mainly through regular wages and salaries and social status.
- Material deprivation, resulting from unemployment or low-paid work and feelings of unfair pay – such as high levels of wage disparities within organizations – contribute to physical and mental ill health.
- Occupational position is important for people's social status and social identity, and threats to social status from job instability or job loss affect health and well-being.
- An adverse psychosocial work environment defined by high demand and low control, or an imbalance between efforts spent and rewards received, is associated with an increase in stress-related conditions; such exposure follows a social gradient (Fig. 7).
- Experiences of discrimination, harassment and injustice aggravate stress and conflict at work, especially in times of high competition and increasing job insecurity.
- Exposure to physical, ergonomic and chemical hazards at the workplace, physically demanding or dangerous work, long or irregular work hours, temporary contract and shift work and prolonged sedentary work can all adversely affect the health of working people.

Fig. 7. Psychosocial stress and occupational class in selected countries in the WHO European Region



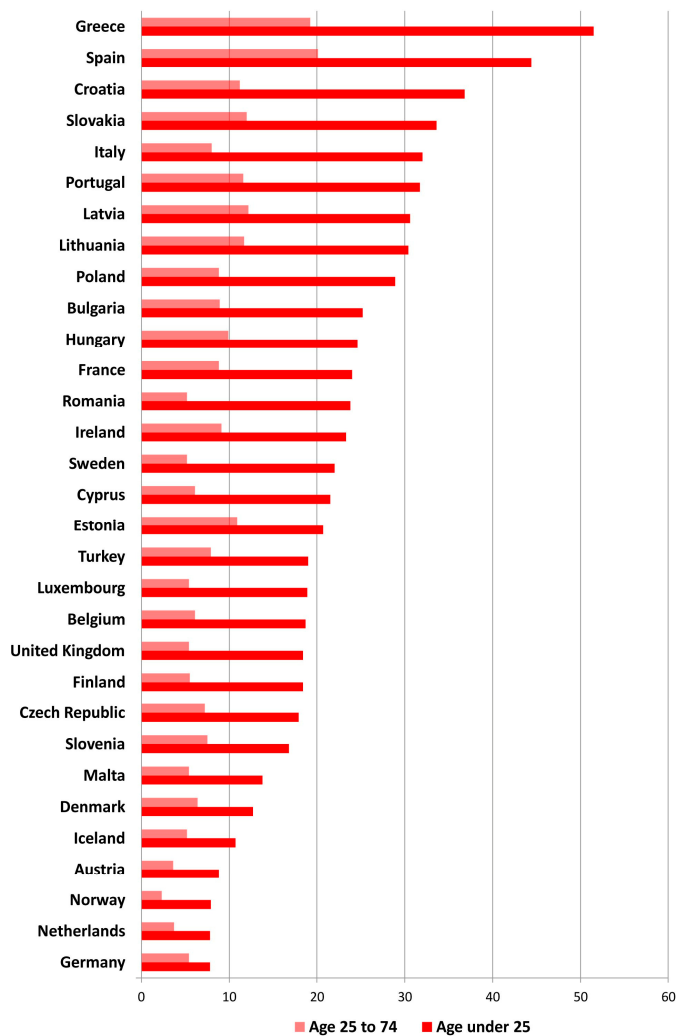
Source: Wahrendorf & Siegrist (12) based on data from 12 European countries in the Survey of Health, Ageing and Retirement in Europe (13).

Levels of unemployment across the European Region are high and vary substantially by country, age, sex, migrant status and educational level. They have recently risen considerably in the countries most affected by recession and the economic crisis, such as Spain and Greece. Fig. 8 and 9 illustrate the great variation across the Region.

There is comprehensive scientific evidence on increased health risks resulting from precarious employment, which carries a heightened risk of becoming unemployed, and from unemployment itself – particularly from long-term unemployment.

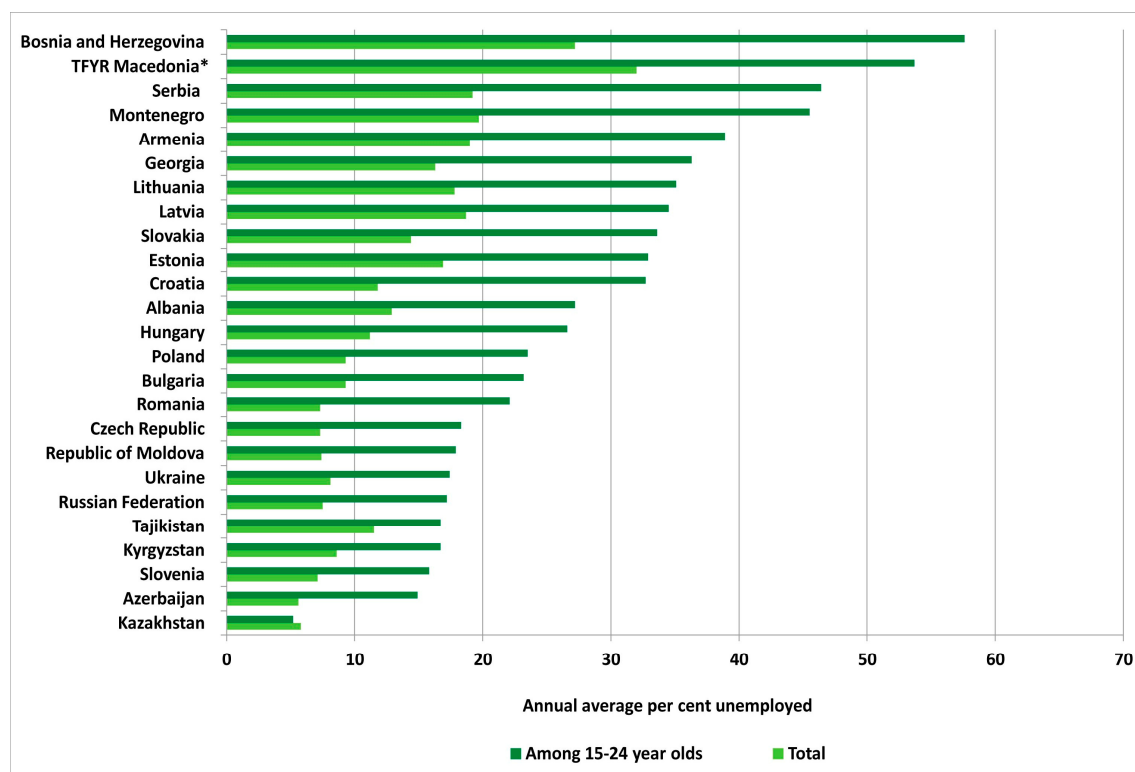
The review recommendations address the causes of inequities in ill health associated with work conditions and unemployment.

Fig. 8. Unemployment rates among women in selected countries in the WHO European Region by age, 2011



Source: *Unemployment rate by age group* (Labour Force Survey 2011) (14).

Fig. 9. Unemployment rate in countries in the central and eastern parts of the WHO European Region by age, 2009 (Labour Force Survey, 2010)



TFYR Macedonia: the former Yugoslav Republic of Macedonia.

Source: TransMONEE database [online database] (15) based on the Labour Force Survey 2009.

Note: the data for Tajikistan are for 2009 and the data for Albania are for 2008.

Older ages

Recommendation 1(d)

Introduce coherent effective intersectoral action to tackle inequities at older ages, both to prevent and manage the development of chronic morbidity and to improve survival and well-being across the social gradient.

Specific actions

- (i) Focus action on addressing social isolation, living conditions, adequacy of pensions, opportunities for physical activity and access to health and social care.
- (ii) Devote particular attention and action to the social, economic and health problems of older women who have more physical and mental health problems in old age, a greater risk of poverty and live more years with disability.

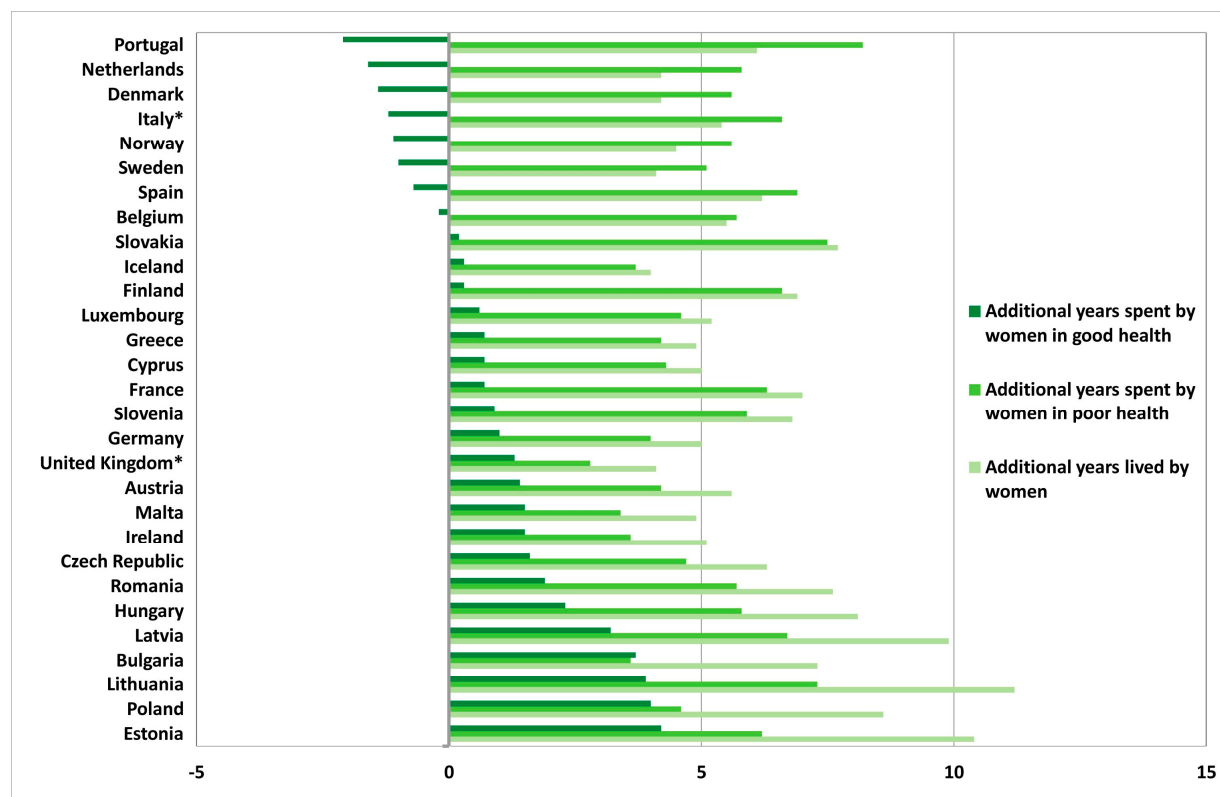
Understanding the underlying determinants of health and inequities among older people is an important priority for the European Region, the region in which population ageing is most advanced. Effective strategies are required to promote healthy, active and independent lives in old age, through early preventive action to delay the onset of age-related mental and physical disabilities. Proportionally more attention needs to be paid to older adults with lower incomes in designing these preventive programmes. In addition, policies aimed at tackling social and economic inequities, in general, such as redistribution schemes and those focused on tackling

financial barriers in access to care should all be designed to reduce inequities among the older population.

Fig. 10 shows how the gender gaps in the time men and women can expect to live and be in good health vary between countries in the Region. It shows that, in every country, women live longer than men but spend more years not in good health. In Portugal, women live six years longer than men but spend eight more years not in good health. Conversely, in Estonia, women live 11 years longer than men but only 6 years longer not in good health.

In addition to focusing on the causes of shorter longevity among men in the Region, special attention should be devoted to older women, who have more health problems and are at greater risk of poverty in old age because they live longer and have a different life course. Chronic rather than acute morbidity is the most consistent explanatory factor for differences in health and disability between men and women. Many age-related mental health problems are also more common among women. Older people may experience discrimination or disregard and social isolation because of their age. Social isolation is a powerful predictor of mortality.

Fig. 10. Differences between women and men in healthy life-years, years not in good health and life expectancy at birth in selected countries, WHO European Region, 2009



Source: Healthy life years and life expectancy at birth, by gender (16).

*The data for Italy and United Kingdom are for 2008.

Theme B – Wider society

Recommendation 2(a)

Improve the level and distribution of social protection, according to needs, as to improve health and address health inequities.

Specific actions

- (i) Spend more on social protection, particularly in countries with the lowest levels of social spending in the WHO European Region. Increasing social protection for those countries with very small social protection systems has proportionately greater impact than increased spending in countries with more generous social protection systems. This can be summarized as follows.
 - *Do something*; In countries characterized by small amounts of effort, in terms of social protection, make some programme improvements;
 - *Do more*; In countries characterized by medium to high ambitions in terms of social protection policies, further increase the ambitions of social protection programmes;
 - *Do better*; Among the most developed welfare states, where the redistributive and protective capacity of the welfare state has diminished, improve the levels of social protection in general and for the most vulnerable people in particular;
- (ii) Make more effective use of the resources already used for social protection.
- (iii) Ensure a minimum standard for healthy living for all. This is not an absolute standard but one that needs to be determined country by country, based on developing national criteria using a standard international framework.
- (iv) Adopt a gender equity approach to tackle social and economic inequities resulting from women being overrepresented in part-time work, getting less pay for the same job and undertaking unpaid caring roles.

Social protection

Social protection policies can create a buffer against income loss and can redistribute income both over the life course and between individuals. Individuals and families can also draw on the collective resources provided by welfare state institutions. Both are important for health and well-being. For this reason, the welfare resources necessary to have an acceptable quality of life – including economic resources, working conditions, housing conditions, education and knowledge – constitute key social determinants of health.

The less people achieve in terms of individual resources, the more important it is that they be able to draw on collective resources – welfare policies that provide more generous transfers and better-quality services are likely to improve public health and reduce health inequities. A major problem in the European Region is not only low income associated with unemployment but employment that pays too little to lead a healthy life.

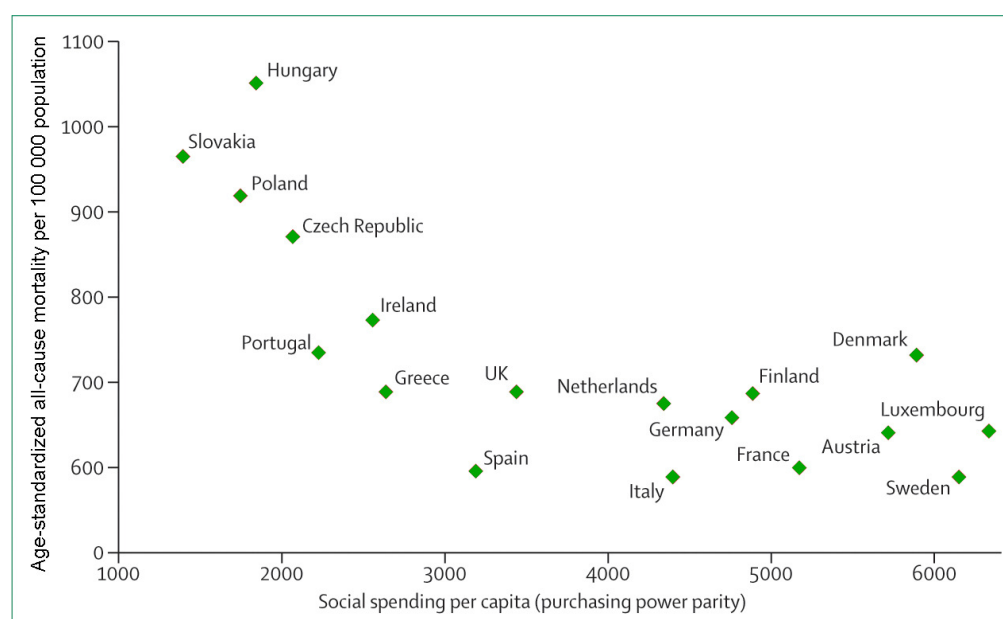
People with low levels of education tend to benefit more from higher levels of social transfers than those with secondary and tertiary education. In both absolute and relative terms, educational inequities in health decrease as social spending increases; and, the effect that increased spending has on these inequities is greater for women than for men.

Where existing levels of social spending and social rights are in the low to moderate range, even **small improvements in legislated social rights and social spending are associated with improved health** (Fig. 11). This suggests that countries with the least developed social protection

systems can make gains most easily. Even modest increases would be of importance in poorer countries in the Region.

The objective of the joint United Nations Social Protection Floor Initiative (SPF-I) is to ensure a basic level of social protection and a decent life both as a necessity and an obligation under the human rights instruments (17). A key aim of policy in the European region should be the maintenance of minimum standards needed for healthy living

Fig. 11. Social welfare spending and all-cause mortality in 18 countries, WHO European Region, 2000



Source: Stuckler et al. (18).

Gender

The social and economic roles performed by men and women significantly affect the health risks to which they are exposed over the life course. A specific source of psychosocial stress for women over the life course is balancing the burdens of caregiving to different generations, paid work and housekeeping. Men's health is more frequently affected by work conditions. Risk-taking and other behaviour among men, such as violence, are encouraged by gender norms and endanger the health and well-being of both men and women.

Societal and economic changes affect gender roles, but societal norms and values may limit the extent to which the people affected adapt. The combined effect of these is to alter health outcomes and the extent of the gender gap – for example, the current 13-year life expectancy gap between males and females in the Russian Federation. For these reasons, although differences in mortality and morbidity rates between men and women are well documented, the scale of these varies widely across the WHO European Region and is changing in many countries. The

appropriate response is to adopt a gender equity approach in tackling social and economic inequities.

Local communities

Recommendation 2(b)

Ensure that concerted efforts are made to reduce inequities in the local determinants of health through both co-creation and partnership with those affected, civil society and a range of civic partners.

Specific actions

- (i) Ensure championing of partnership and cross-sector working by local leaders.
- (ii) Ensure that all actions are based on informed and inclusive methods for public engagement and community participation, according to locally appropriate context, to empower communities and build resilience
- (iii) Make partnership working more extensive, including the use of individual agencies and physical resources – schools, health and community centres – as the basis for a range of other services.
- (iv) Give priority, in environmental policies, to measures that help to improve health and apply to all population groups likely to be affected, particularly those who are excluded (such as homeless people and refugees) or vulnerable people (such as young and older people).
- (v) Adopt strategies to improve air quality and reduce health risks from air pollutants for all groups across the social gradient.

Communities are influenced and shaped by the complex interrelationships between the natural, built and social environments. The lower people are on the socioeconomic gradient, the more likely they are to live in areas where the built environment is of poorer quality and is less conducive to positive health behaviour and outcomes and where exposure to environmental factors that are detrimental to health is more likely to occur (19).

People who live in areas of higher deprivation are more likely to be affected by tobacco smoke, biological and chemical contamination, hazardous waste sites, air pollution, flooding, sanitation and water scarcity, noise pollution and road traffic (20). At the same time, they are less likely to live in decent housing and in sociable and congenial places of high social capital that feel safe from crime and disorder, provide access to green spaces and have adequate transport options and opportunities for healthy living.

People on low incomes are less likely to have the means and resources to mitigate the risks and effects of environmental hazards and to overcome the obstacles posed by environmental disadvantages to securing less hazardous conditions and access to opportunities.

How people experience social relationships influences health inequities. Critical factors include how much control people have over resources and decision-making and how much access people have to social resources, including social networks, and communal capabilities and resilience. Social capital has been identified as a catalyst for coordination and cooperation, serving as an essential means to achieve better social and economic outcomes. There is, however, no consistency in the factors that are associated with strong social networks and social capital. Although this argues against excessive generalization, some evidence indicates that social networks appear, in general, to be stronger in countries with higher poverty rates; social capital tends to be more easily built in countries with relatively strong democracies that have effective legal systems; and that strong civil societies contribute to building strong democracies (21).

Spatial quality – how places and spaces are planned, designed, constructed and managed – affects the distribution of environmental burdens and benefits affecting health and inequities (Table 1). The quality of infrastructure, including water and sanitation, are crucial to health, along with other factors. Immigrant communities and people living in slum conditions throughout the European Region often live in the most polluted areas (22). Across the central and eastern parts of the Region, especially in the former Soviet republics, hazardous waste and chemicals are major contributors to environmental injustice (23). Access to safe water has recently deteriorated in several countries in the eastern part of the Region, although the situation has been improving in this area as a whole (24). Although people living in rural areas tend to have little access to sanitation (25), the poorer groups in urban areas bear the greatest impact of droughts affecting the water supply (26). Improving the environment has been one of the rallying points of civil society in the eastern part of the Region.

Table 1. Poor quality of the built environment affects health: summary of exposure, population-attributable fraction from inadequate housing conditions

Exposure	Health outcomes	Exposure–risk relationship	Population-attributable fraction (%)
Mould	Asthma deaths and DALYs in children (0–14 years)	RR = 2.4	12.3
Dampness	Asthma deaths and DALYs in children (0–14 years)	RR = 2.2	15.3
Lack of window guards	Injury deaths and DALYs in children (0–14 years)	RR = 2.0	33–47
Lack of smoke detectors	Injury deaths and DALYs (all ages)	RR = 2.0	2–50
Crowding	Tuberculosis	RR = 1.5	4.8
Indoor cold	Excess winter mortality	0.15% increased mortality per °C	30
Traffic noise	Ischaemic heart disease including myocardial infarction	RR = 1.17 per 10 dB(A)	2.9
Radon	Lung cancer	RR = 1.08 per 100 Bq/m ³	2–12
Residential second-hand smoke	Lower respiratory infections, asthma, heart disease and lung cancer	Risk estimates range from 1.2 to 2.0; OR = 4.4	Estimates range from 0.6% to 23%
Lead	Mental retardation, cardiovascular disease, behavioural problems	Case fatality rate 3%	66
Indoor carbon monoxide	Headache, nausea, cardiovascular ischaemia/insufficiency, seizures, coma, loss of consciousness, death	DNS/PNS incidence 3–40%	50–64
Formaldehyde	Lower respiratory symptoms in children	OR = 1.4	3.7
Indoor solid fuel use	COPD, ALRI, lung cancer	RR = 1.5–3.2	6–15

DALYs: disability-adjusted life-years. RR: relative risk. OR: odds ratio. DNS/PNS: delayed or persistent neurocognitive sequelae. COPD: chronic obstructive pulmonary disease. ALRI: acute lower respiratory infection.

Source: Braubach et al. (27).

Social exclusion, vulnerability and disadvantage

Recommendation 2(c)

Take action on socially excluded groups, building on and extending existing systems that are in place for the wider society, with the aim of creating systems that are more sustainable, cohesive and inclusive.

Specific actions

- (i) Address the social determinants of health and well-being among people exposed to processes that lead to social exclusion:
 - avoid focusing on the individual attributes and behaviours of those who are socially excluded; and
 - focus on action across the social gradient in health that is proportional to need rather than the gap in health between the most and least disadvantaged groups.
- (ii) Involve individuals and groups who are socially excluded in developing and implementing policy and action by putting in place effective mechanisms that give them a real say in decisions that affect their lives and by recognizing their fundamental rights (such as to health, education, employment and housing).
- (iii) Develop strategies that:
 - focus action on releasing capacity within organizations, professional groups and disadvantaged groups to achieve long-term improvements in resilience and how those who are socially excluded are able to live their lives;
 - make a corresponding reduction in the focus on short-term spending projects; and
 - empower disadvantaged groups in their relationships with societal systems with which they have contact.
 - focus action on releasing capacity within organizations, professional groups and disadvantaged groups to achieve long-term improvements in resilience and how those who are socially excluded are able to live their lives;
 - make a corresponding reduction in the focus on short-term spending projects; and
 - empower disadvantaged groups in their relationships with societal systems with which they have contact.

From the perspective of the social determinants of health, it is important to understand exclusion, vulnerability and resilience as dynamic multidimensional processes operating through relationships of power. Previously, exclusion has too often been approached by focusing on the attributes of specific excluded groups.

Recognizing that exclusionary processes and vulnerabilities vary among groups and societies over time suggests that action should be based on addressing the existence of continuums of inclusion and exclusion and vulnerability. This does not deny the existence of extreme states of exclusion, but it helps avoid the stigmatization inherent in an approach that labels particular groups as “excluded”, “disadvantaged” and/or “vulnerable”. This continuum approach should also increase understanding of the processes at work and how these might be reversed and shift the focus from passive victims towards the potential for disadvantaged groups to be resilient in the face of vulnerability. The review focused on two important examples: vulnerability among Roma and among irregular migrants – people without permission to either live or work in the country of residence.

Roma

The exposure of Europe's Roma to powerful social, economic, political and cultural exclusionary processes, including prejudice and discrimination, adversely affects their human rights and self-determination. Progress in reducing the social inequities experienced by Roma has been limited. This situation is leading to gross inequities in health and well-being among the Roma compared with other populations in the WHO European Region.

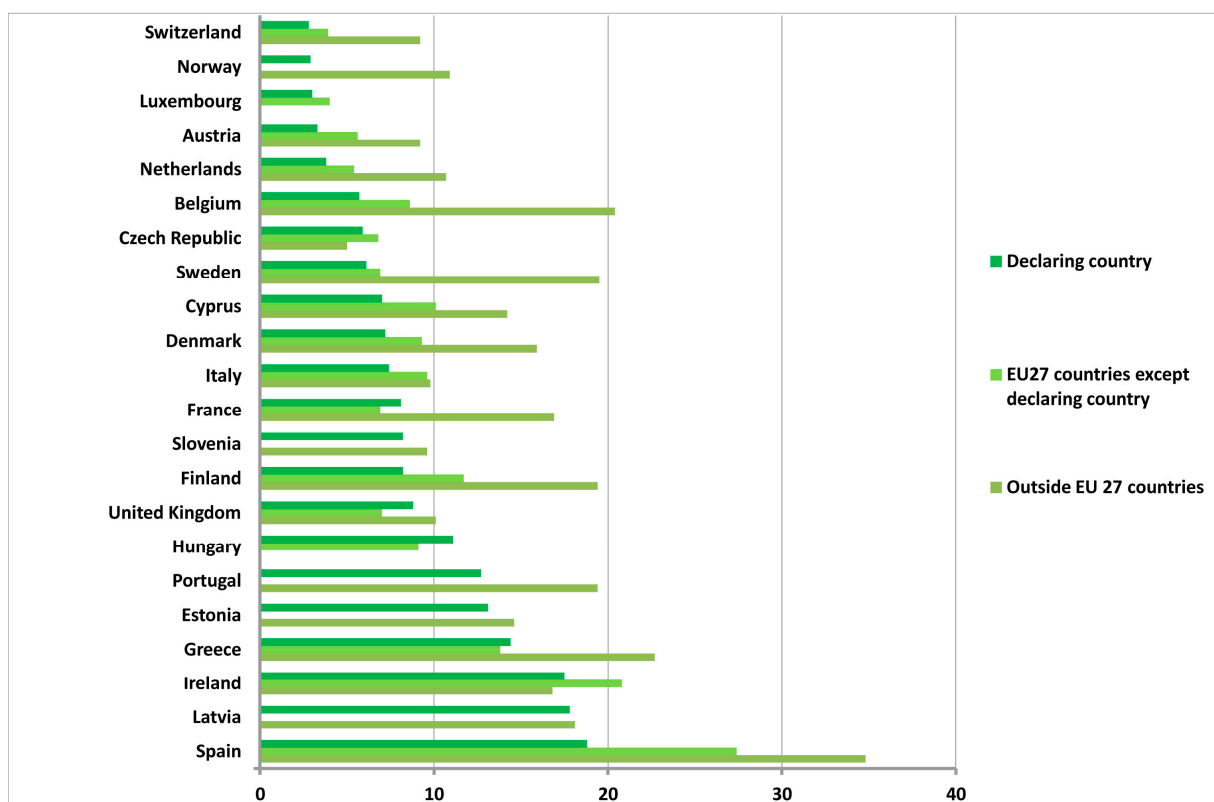
Factors affecting progress and implementation including: the complexity of funding arrangements; lack of data for monitoring and evaluation purposes; inadequate systems of governance and accountability; insufficient participation of Roma people and civil society; and an absence of political will. These problems need to be addressed through political commitment both at national and trans-national levels.

The Decade of Roma Inclusion provides a valuable example of this – a commitment by 12 European governments to improve the socioeconomic status and social inclusion of Roma. During this initiative, no single country performed consistently well across all the policy areas. However, positive outcomes were achieved by several specific initiatives: for example, active participation of Roma in housing developments in Hungary and the establishment of recycling centres and cooperatives in Serbia.

Irregular migrants

As an indicator of lack of participation in societal opportunities, Fig. 12 shows that unemployment rates are higher among migrants in many countries. Irregular migrants who are particularly exposed to additional exclusionary processes face the greatest problems – for example, those who need health care, unaccompanied minors, irregular female domestic workers and victims of trafficking – mostly women being exploited in the sex trade. States vary in the extent to which they allow irregular migrants access to social protection, including health care. Withholding access, denying them the “right to the highest attainable health”, is seen as one important element of “internal migration control”, and detention is another. However, these measures do not seem to have much effect on the numbers of irregular migrants – their main effect is increased vulnerability to marginalization, destitution, illness and exploitation. Migration issues and the living conditions of regular and irregular migrants need to be addressed by agreements between countries in the Region that do not infringe their human rights.

Fig. 12. Unemployment rates in selected countries in the WHO European Region by country of birth, 2011



Source: *Supplementary indicators to unemployment, annual average, by sex and nationality (1000 persons) (28).*

Theme C – Macro level context

Economic issues

Recommendation 3(a)

Use the system of taxes and transfers to promote equity as effectively as possible. The proportion of the budget spent on health and social protection programmes should be increased for countries below the current EU average.

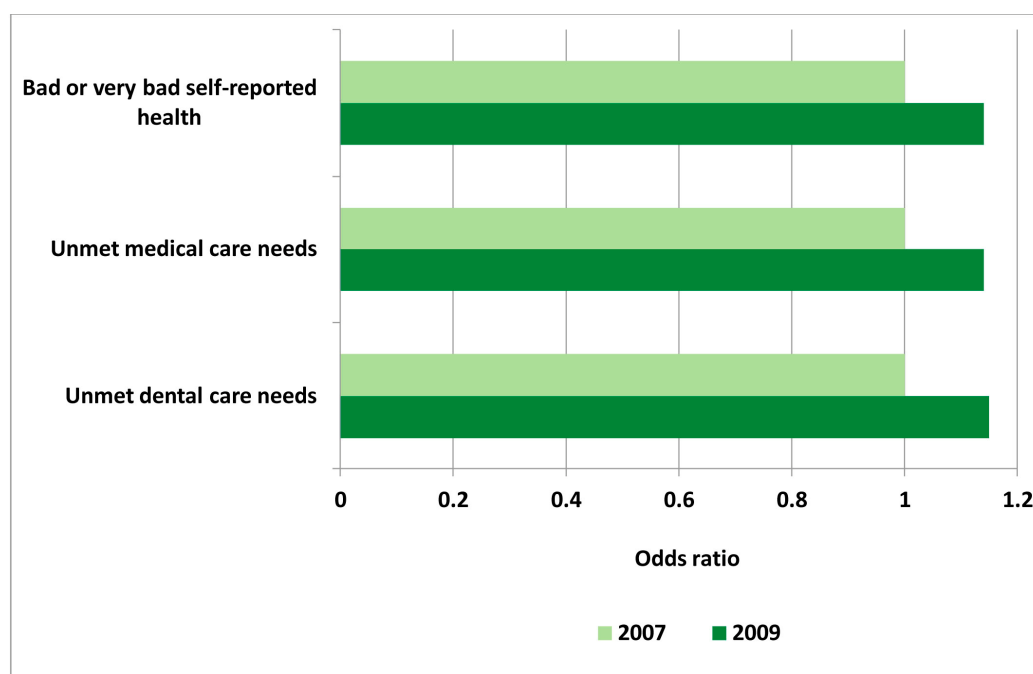
Specific actions

- (i) Improve the balance between the overall level of social spending and (a) expenditure on other programmes and (b) the overall level of taxation in the countries in which these indicators are below the current EU average. In achieving these balances, promote equity effectively by adopting best practices in designing social spending programmes, including universal provision that is proportional to need and integrated social care and labour market policies that incorporate active labour market programmes.
- (ii) In addressing the economic crisis, ensure that priority is given to the health and social consequences of the austerity packages that are now being discussed or have already been introduced in many countries in the Region. Ensure that the views of health and social affairs ministers are heard in the negotiations about such austerity packages. In particular, at a transnational level, ensure that WHO, UNICEF, ILO and the World Bank are given a voice.
- (iii) Widen the discussion of financial stability mechanisms to give priority to socially progressive policies: for example, by considering the likely impact of taxing financial transactions.

The background to the review is the global financial crisis and the related sovereign debt crisis. They are likely to have a direct, negative, lasting effect on health and its social determinants in Europe, particularly if the response to the financial and debt crises does not take health equity concerns into account. For example, the direct health effects are already becoming evident in some countries in the Region (Fig. 13).

This highlights the need to protect the social and health sectors from austerity-driven cuts and from some of the negative effects of financial support agreements between countries in the Region and transnational bodies, by using other measures that have smaller negative effects, both economically and on health, whenever these are available.

Fig. 13. Changes in self-reported health and access to health care in Greece between 2007 and 2009, adjusted estimates



Source: Kentikelenis et al. (29).

Note: In this figure, the odds ratio refers to the odds of ill health or unmet need in each year compared with the odds in 2007, so that the odds ratio in 2007 equals 1 for each indicator.

Sustainability and environment

Recommendation 3(b)

Plan for the long-term and safeguard the interests of future generations by identifying links between environmental, social and economic factors and their centrality to all policies and practice.

Specific actions

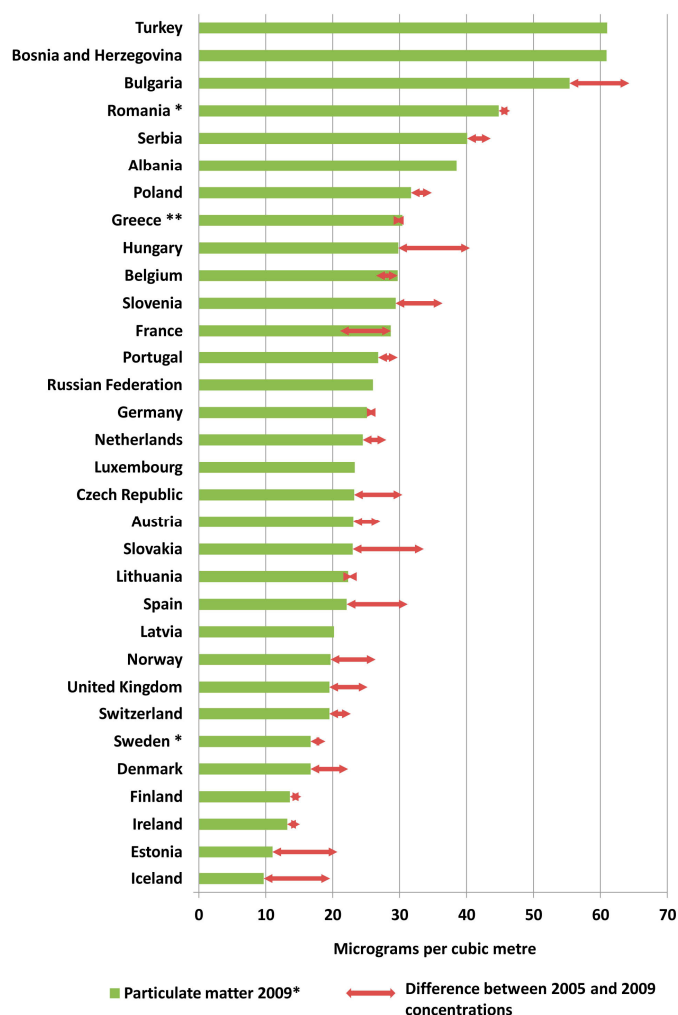
- (i) Ensure that the principles of sustainable development are applied to all policies, taking account of evidence on how development in the past affects current and future generations.
- (ii) Include health equity assessments for current and future generations in environmental policies at all levels.
- (iii) Introduce fiscal policies that improve the affordability of healthy and sustainable food choices:
 - Ensure that the cost of nutritious and sustainable diet is reflected in calculations of a minimum standard of living for all;
 - Ground agricultural policies in equity and sustainability and ensure that they promote access to safe, affordable, nutritious food for all, and sustainable and equitable food systems

Environmental quality is linked to social equity: where environmental harm occurs it is often linked to the unequal distribution of environmental hazards. Factors determining health and social justice are interdependent with factors determining environmental and economic sustainability. For example, excessive consumption of animal fat is associated with increased risk of preventable diet-related diseases, including several types of cancer and cardiovascular disease, while producing animal-based food to supply demand is associated with environmental

costs, including water use and greenhouse-gas emissions. If low-income countries seek to develop their economies by emulating industrialized economies, this may have dire consequences for the natural environment and for health and health inequities across the Region. Populations in low- and middle-income countries in the Region are likely to reap the greatest benefit from interventions that provide a healthier and safer environment, since they tend to be disproportionately exposed to inadequate environmental conditions (22). Fig. 14 illustrates the unequal levels of air pollution in capital cities in the Region.

Integral to facing this challenge of reducing inequitable environmental harm is an approach, endorsed in the 2011 Rio Political Declaration on Social Determinants of Health, that embraces sustainable development. Some progress has been made in the last two decades, for example, energy efficiency, in terms of energy use per dollar of GDP, has improved in countries in the eastern part of the Region and in EU countries (31) (Fig. 15), but much more needs to be done.

Fig. 14. Annual average concentrations of particulate matter, in the capital city in 2009 and change since 2005, selected countries, WHO European Region

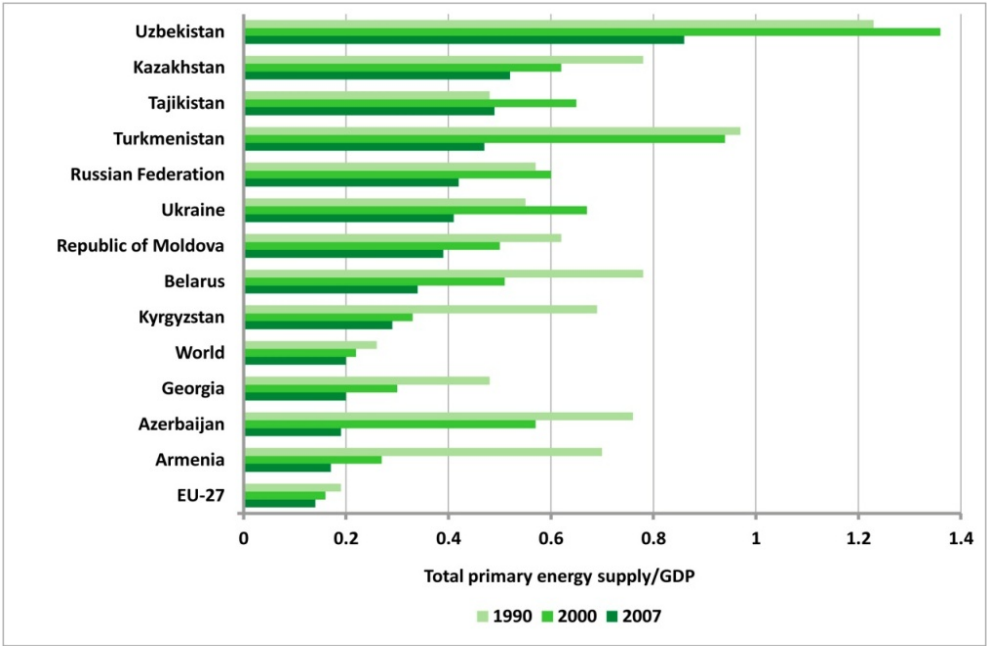


Source: European Health for All database [online database] (2).

*The latest figures for Romania and Sweden are for 2008. **The latest figures for Greece are for 2007.

Note: The solid bars represent the level of particulate matter in 2009. Where the arrows are to the right of the bars, this indicates that levels fell between 2005 and 2009. Where the arrows are to the left of the end of the solid bar, levels increased between 2005 and 2009.

Fig. 15. GDP energy intensity in selected countries in the eastern part of the WHO European Region, EU27 and world average



Source: Olshanskaya (30).

Theme D – Systems

Governance and delivery

Recommendation 4(a)

Governance for social determinants of health and health equity requires greater coherence of action at all levels of government – transnational, national, regional and local – and across all sectors and stakeholders – public, private, and voluntary.

Specific actions

- (i) At the regional level, ensure that WHO Regional Office for Europe and its partner United Nations organizations in Europe work together through the United Nations collaboration mechanism to have a voice in transnational agreements affecting the social determinants of health.
- (ii) Strengthen the role of WHO to be in a position where it has the capacity and legitimacy to advise Member States on developing policies on the social determinants of health and be an advocate for health equity in other relevant sectors.
- (iii) Develop partnerships at all levels of government that put in place collaborative models of working based on shared priorities with other sectors.
- (iv) Ensure that the coherence of actions across sectors and stakeholders is strengthened, to achieve:
 - sufficient intensity of action –increase the resources devoted to redressing current patterns and magnitude of health inequities;
 - long-term investment and sustainability of actions; and
 - levelling up the gradient in health equity and the social determinants of health.
- (v) Ensure that the different needs, perspectives, and human rights of groups at risk of marginalization and vulnerability are heard through their involvement in decision-making processes. Accompany this by effective mechanisms for adequate participation, engagement and consultation with all parts of civil society.

Governance for social determinants of health and health equity seeks to strengthen the coherence of actions across sectors and stakeholders in a manner that increases resources to (a) redress current patterns and magnitude of health inequities and (b) reduce inequities in the distribution of the social determinants of health and of the risks and consequences of disease and premature mortality across the population.

Governance for health comprises: “the attempts of governments or other actors to steer communities, whole countries, or even groups of countries in the pursuit of health as integral to well-being through both a whole-of-society and a whole-of-government approach” (31).

At the European Region level, it is necessary to develop a much stronger institutional framework for this, based on mutual agreements between countries and involving the WHO Regional Office for Europe and its partner organizations. At every level of governance, arrangements are needed that are capable of building and ensuring joint action and accountability of health and non-health sectors, public and private actors and ordinary people, with a common interest in improving health on equal terms. Fig. 16 illustrates the different levels of voice and accountability seen across the Region.

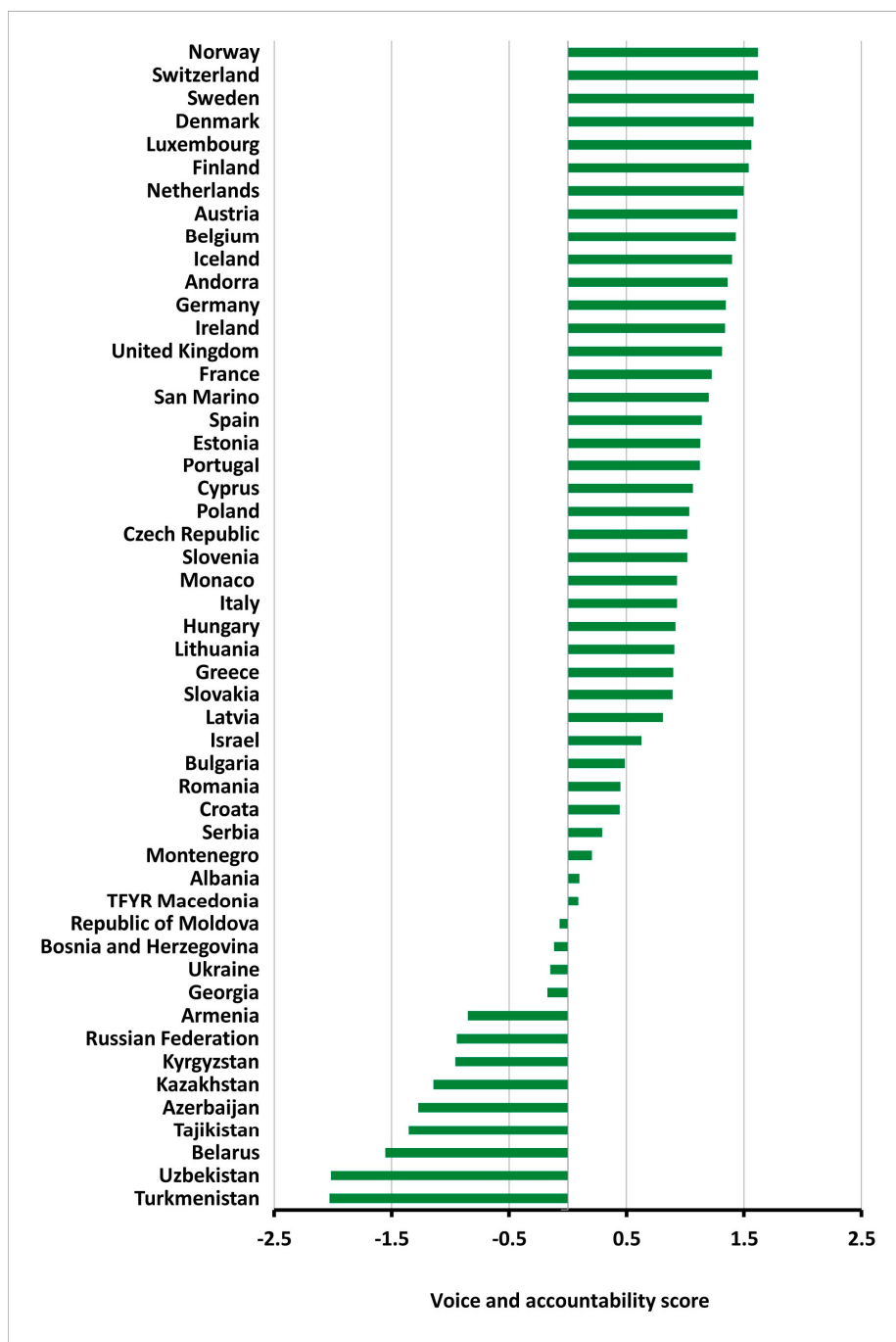
Key competencies that governance for health systems need to deliver strategies for addressing the social determinants of health

- High level of political will and commitment, globally, nationally and locally
- Transnational mechanisms that promote health and equity
- Accountability mechanisms
 - transparent
 - based on empowerment
- Equity in all policies
- Appropriate levers and incentives
- Institutional readiness
- Collaboration and action from key stakeholders
- Rights-based approach
- Involve communities
 - Draw on and strengthen capabilities and assets
- Cross-sectoral and partnership working
 - Embedded in existing management and performance systems

A key action area is to develop new instruments and mechanisms – and strengthen those that exist – to empower people and ensure that the opinions and perspectives that are heard in decision-making processes include a better reflection of equity arguments. Empowering people includes promoting civil society, enabling unions to be formed and developing political and non-political organizations freely.

Participatory mechanisms such as citizen's juries, consumer panels and community planning methods have the potential to engage the diversity of stakeholders with an interest in the social determinants of health and provide new ways of holding decision-makers more accountable for their actions. They also promote greater political involvement across societies and contribute to more equitable allocation of resources.

Fig. 16. Voice and accountability scores of countries in the WHO European Region according to the World Bank Worldwide Governance Indicators



TFYR Macedonia: the former Yugoslav Republic of Macedonia.
Source: *The Worldwide Governance Indicators, 2011 update (32)*.

Prevention and treatment of ill health

Recommendation 4(b)

The long-term nature of preventing and treating ill health equitably requires a comprehensive response to achieve sustained and equitable change in preventing and treating ill health.

Specific actions

Prevention

Ensure that actions on preventable health hazards are based on addressing the substantial differences in exposure both within and between countries. Include:

- Reduce harmful alcohol consumption – such as a tax on alcoholic beverages that is proportional to the alcohol content in the beverage
- Initiate wider action to reduce fat, particularly trans-fatty acids, in diet, and control the growth of fast-food consumption.
- Take action to reduce smoking under the WHO Framework Convention on Tobacco Control.
- Encourage active living, focusing on needs across the social gradient.

Treatment

Reduce differential access to good-quality health care services within and between countries, including action to do the following.

- Make health care systems more equitable – universal health coverage is required to provide a critical foundation for addressing health inequities.
- Remove financial, geographical and cultural barriers to the uptake of health care services –such as co-payments – and ensure adequate resource allocation to disadvantaged areas.

Strategies

Ensure that strategies to address inequities within and between countries, including those related to gender, cover the following.

- Strengthen health promotion, health protection and disease prevention systems to ensure universal coverage for all social groups, and link these to policies and programmes that specifically address the determinants of lifestyles and behaviour.
- Improve the accessibility and quality of health care services.
- WHO, the European Union and individual countries in the western part of the Region must provide support for developing and implementing these strategies to address inequities in countries where they are weakest, including some countries in the eastern part of the Region.

Ensure a balance between strategies that have short-, medium- and longer-term results and between simpler and more complex, integrated interventions. Specific areas for action are:

- strategies that give societies, groups and individuals greater control over their exposure to preventable hazards such as regulation and control over the workplace and the environment, tobacco, alcohol and food content and availability and pricing as well as addressing societal norms and values;
- design screening programmes to be accessible by all, particularly the most vulnerable and disadvantaged people, for cardiovascular risk factors and early detection of cancer
- ensure the effective implementation of infectious disease strategies (such as tuberculosis and HIV) that disproportionately affect socially disadvantaged and vulnerable people – including addressing the causes of vulnerability, gender inequities and adequate, sustainable access to screening, diagnosis and treatment services.
- Across these recommendations, monitor and assess the effects on population health equity disaggregated by sex, age and 2–3 key socioeconomic determinants.

A comprehensive health system response is required to prevent and treat ill health equitably. Many actions can be taken now to improve population health in the short and medium term, whereas others will take longer to have an impact. Achieving sustained and equitable change in preventing and treating ill health therefore requires achieving a balance between strategies that have short-, medium- and longer-term results as well as between simpler and more complex, integrated interventions.

Between-country differences

Reasonably good evidence indicates that part of the health divide between countries in the Region is associated with (a) differences in exposure to preventable health hazards that result from inequities in the social determinants of health and of behaviour and lifestyles – including inequities in exposure to tobacco, alcohol, unhealthy diets, high blood pressure, risk of cervical cancer, conditions leading to road injury, dangerous or stressful working conditions and air pollution and (b) differences in the accessibility and quality of health care services.

The contribution of these factors, however, differs between countries and over time. For example, excessive alcohol consumption is relatively more important in some countries in central and eastern Europe as a determinant of poor population health, and smoking, while being one of the main downstream determinants of health inequities in northern and western part of the Region, is not a major determinant of health inequities in the southern part of the Region. The contribution of differential access to good-quality health care services also varies between countries. Although inadequate access to effective care may make only a modest contribution to the observed health inequities in northern, western and southern Europe, it is likely to have a stronger influence on the larger inequities in mortality observed in the eastern part of the Region.

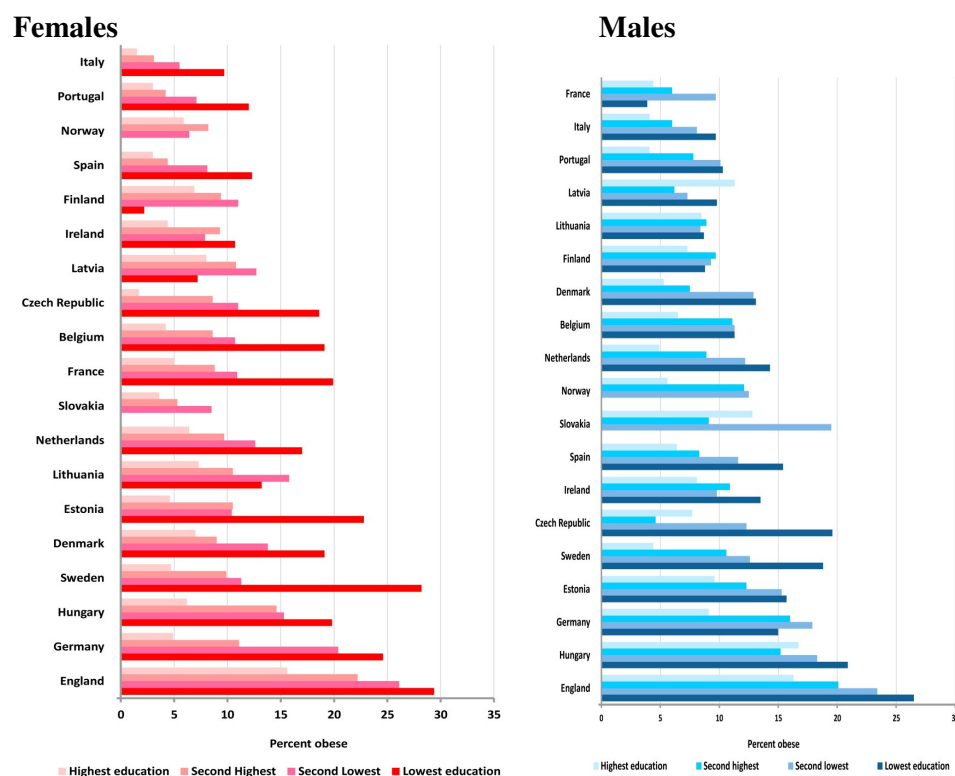
The evidence on these different contributions provides important entry-points to policies for preventing and treating ill health designed to reducing the health divide between countries. Two important strategies are (a) strengthening health promotion, health protection and disease prevention in the central and eastern parts of the Region and (b) making improvements that reduce differences in the accessibility and quality of health care services.

Within-country differences

The exposure to preventable health hazards that arises from social determinants, as described above, contributes to socioeconomic inequities in health within countries. This is observed, for example, in relation to levels of obesity according to education (Fig. 17). The contribution of such health risks as exposure to tobacco smoke, unhealthy diet, physical inactivity and misuse of alcohol differs across the Region, because of local social norms and values and the stage that behaviour-related epidemics have reached. The response to this requires appropriate country-specific priorities and strategies that encompass equity issues. Where WHO strategies and framework statements exist, they provide a basis for developing this response.

Similarly, treatment strategies to tackle health inequities within countries must also be adapted to national priorities and specific health systems, within a framework of equity and an aspiration of universal provision for the population as a whole – with resources allocated according to social need and provision for disadvantaged groups.

Fig. 17. Percentage of the population that is obese by level of education and sex, selected countries, WHO European Region



Source: Roskam et al. (33).

Evidence and monitoring

Recommendation 4(c)

Undertake regular reporting and public scrutiny of inequities in health and its social determinants at all governance levels, including transnational, country and local levels.

Specific actions

- (i) In all countries, establish clear strategies – based on local evidence – to redress the current patterns and magnitude of health inequities by taking action on the social determinants of health.
- (ii) Include in these strategies monitoring of both the social determinants of health across the life course and the social and geographical distributions of outcomes.
- (iii) Undertake periodic reviews of these strategies at all governance levels that include in-depth analytical descriptions of the magnitude and trends in inequalities in health and the main determinants that generate them.
- (iv) At the country level, provide regular reports on their reviews to WHO for discussion at regular regional meetings.
- (v) Ensure progressive improvement in the availability and access to data needed to achieve this – both in terms of monitoring of trends and evaluation of what actions are most effective.
- (vi) WHO and the EU ensure that they work together to set minimum standards for the data required to achieve this.
- (vii) Initiate the strategy review process today – there is currently sufficient information in every country in the Region to do this.

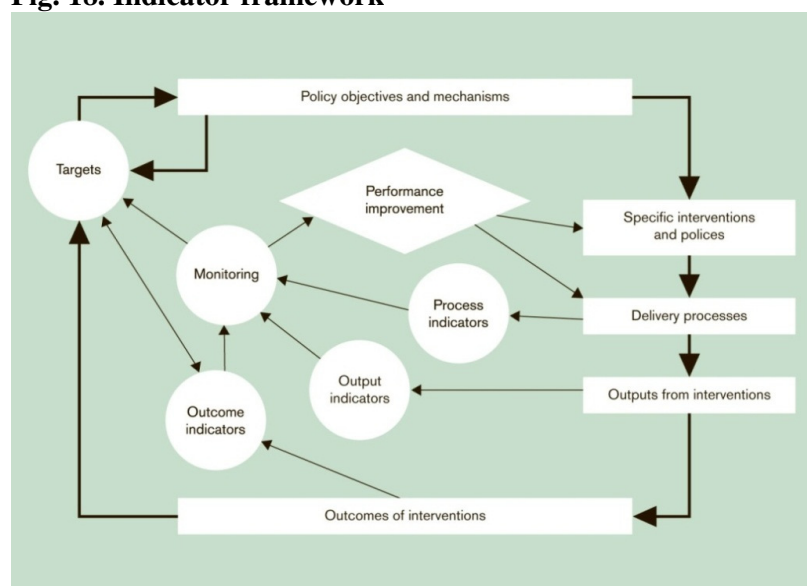
Improving health and health equity requires an approach that is based on evidence and up-to-date information. A monitoring system that supplies information to policy-makers and other stakeholders about the distribution and trends in health outcomes, risk factors, ill health prevention and treatment and their determinants is an essential part of the social determinants approach to improving health equity.

One role of a monitoring system is to enable stakeholders to evaluate the impact of policies and interventions and whether the benefits are fairly distributed to promote a long and healthy life for all. However, the time lags between policy interventions and their impact on health status, as well as the difficulties of attributing an impact to specific policy interventions, require the use of process and output indicators rather than relying solely on indicators of outcomes. However, outcome data are necessary and, in the final analysis, the definitive criteria.

Although indicators of process, outputs and outcomes are necessary, they are not sufficient to guide policy. Effective mechanisms are needed to enable the individuals and groups who are the targets of policy to be heard and involved in a meaningful way in decisions that affect their lives. An effective monitoring system is essential to support the setting of targets, which are identified as desirable goals. The goals in a health equity-oriented approach are ultimately improvements in health outcomes that raise the health of all groups to the level of the best in society. Currently, the main challenges to setting targets and monitoring progress on social inequities in health and, more broadly, social determinants of health, in the Region are the lack of reliable data and the plethora of existing but not standardized data. European data legislation, including the relevant EU directives, should facilitate rather than hinder such monitoring.

The setting of equity-oriented targets needs to be the result of a political process involving all relevant stakeholders. However, targets require a monitoring framework that is accompanied by data of sufficiently good quality, is comparable over time and can be disaggregated, so that progress towards the target can be assessed effectively. Fig. 18 shows the iterative framework for doing this. This is designed to ensure the correct sequencing of target setting, policy intervention development, implementation and subsequent review, in the light of monitoring results.

Fig. 18. Indicator framework



Source: Marmot Review Team (35).

Conclusions

There are persistent and widespread inequities in health across the European Region. These inequities, both between and within countries, arise from inequities in the distribution of power, money and resources. As such, they are unnecessary and unjust, and tackling them should be a high priority at all levels of governance in the Region.

Action is needed on the social determinants of health – across the life course, in wider social and economic spheres and to protect future generations. Human rights approaches support giving political priority to improving health and reducing inequities in its social determinants. The European economic crisis and the response to it have adversely affected the social determinants of health. Taking action to reduce inequities in the social determinants of health would both improve the prospects for health and bring wider social benefits that enable people to achieve their capabilities.

Countries can use health equity in all policies as a key commitment to inform further action to reduce inequities in health, address its social determinants and to reduce the perpetuation of inequities. Nevertheless, new systems of governance and delivery are also required. These need to operate at all levels of governance – involving both the whole of society and the whole of government. They need to give individuals, groups and communities a real say in decisions that affect their lives.

In all countries in the Region, it is recommended that reducing health inequities should become one of the main criteria used to assess health system performance and the performance of government as a whole. It should also be a principal criterion for assessing the work of the WHO in the Region.

It is recommended that all 53 countries in the Region establish clear strategies to redress the current patterns and magnitude of health inequities by taking action on the social determinants of health. Countries should undertake regular reviews of these strategies. These should be reported to WHO and discussed at regular regional meetings.

It is recognized that European countries are at very different starting-points in terms of health, health equity and socioeconomic development. For some countries in the Region, the recommendations are ambitious and aspirational. Although this may limit what is feasible in the short term and the time-scale for addressing specific issues, it should not affect the long-term aspirations of the strategy. Progressive steps towards realizing these ambitions should be developed, covering the life course – perpetuation across generations, early years, working and older ages; wider societal influences – social protection, communities and social exclusion; the broader context – the economy, sustainability and the environment; and the systems needed for delivery – governance for health, prevention, treatment, the evidence base and monitoring.

This review has compiled robust evidence on what should be done and the action required for implementation. It is crucial that countries across the Region work together to reduce health differences both within and between countries by using and building on this evidence to create strategies that deliver better health for all their populations.

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